condition by the physiologic effects of pregnancy.

(5) RACIAL AND ETHNIC MINORITY GROUP.—The term ''racial and ethnic minority group'' has the meaning given that term in section 1707(g)(1) of the Public Health Service Act (42 U.S.C. 300u–6(g)(1)).

(6) SEVERE MATERNAL MORBIDITY.—The term ''severe maternal morbidity'' means a health condition, including a mental health condition or substance use disorder, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

SEC. 3. SUPPORT BY DEPARTMENT OF VETERANS AFFAIRS OF MATERNITY CARE COORDINATION.

(a) PROGRAM ON MATERNITY CARE COORDINATION.—

(1) IN GENERAL.—The Secretary of Veterans Affairs shall carry out the maternity care coordination program described in Veterans Health Administration Directive 1330.03.

(2) TRAINING AND SUPPORT.—In carrying out the program under paragraph (1), the Secretary shall provide to community maternity care providers training and support with respect to the unique needs of pregnant and postpartum veterans, particularly regarding mental and behavioral health conditions relating to the service of those veterans in the Armed Forces.

(b) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There is authorized to be appropriated to the Secretary $15,000,000 for fiscal year 2022 for the program under subsection (a)(1).

(2) SUPPLEMENT NOT SUPPLANT.—Amounts authorized under paragraph (1) are authorized in addition to any other amounts authorized for maternity health care and coordination for the Department of Veterans Affairs.

(c) DEFINITIONS.—In this section:

(1) COMMUNITY MATERNITY CARE PROVIDERS.—The term ''community maternity care providers'' means maternity care providers located at non-Department facilities who provide maternity care to veterans under section 1703 of title 38, United States Code, or any other law administered by the Secretary of Veterans Affairs.

(2) NON-DEPARTMENT FACILITIES.—The term ''non-Department facilities'' has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 4. REPORT ON MATERNAL MORTALITY AND SEVERE MATERNAL MORBIDITY AMONG PREGNANT AND POSTPARTUM VETERANS.

(a) GAO REPORT.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives, and make publicly available, a report on maternal mortality and severe maternal morbidity among pregnant and postpartum veterans, with a particular focus on racial and ethnic disparities in maternal health outcomes for veterans.

(b) MATTERS INCLUDED.—The report under subsection (a) shall include the following:

(1) To the extent practicable—

(A) the number of pregnant and postpartum veterans who have experienced a pregnancy-related death or pregnancy-associated death in the most recent 10 years of available data;

(B) the rate of pregnancy-related deaths per 100,000 live births for pregnant and postpartum veterans;

(C) the number of cases of severe maternal morbidity among pregnant and postpartum veterans in the most recent year of available data;

(D) an assessment of the racial and ethnic disparities in maternal mortality and severe maternal morbidity rates among pregnant and postpartum veterans;

(E) identification of the causes of maternal mortality and severe maternal morbidity that are unique to veterans, including posttraumatic stress disorder, military sexual trauma, and infertility or miscarriages that may be caused by service in the Armed Forces;

(F) identification of the causes of maternal mortality and severe maternal morbidity that are unique to veterans from racial and ethnic minority groups and such other at-risk populations as the Comptroller General considers appropriate;

(G) identification of any correlations between the former rank of veterans and their maternal health outcomes;

(H) the number of veterans who have been diagnosed with infertility by a health care provider of the Veterans Health Administration each year in the most recent five years, disaggregated by age, race, ethnicity, sex, marital status, and geographical location;

(I) the number of veterans who have received a clinical diagnosis of unexplained infertility by a health care provider of the Veterans Health Administration each year in the most recent five years; and

(J) an assessment of the extent to which the rate of incidence of clinically diagnosed infertility among veterans compare or differ to the rate of incidence of clinically diagnosed infertility among the civilian population.

(2) An assessment of the barriers to determining the information required under paragraph (1) and recommendations for improvements in tracking maternal health outcomes among pregnant and postpartum veterans who—

(A) have health care coverage through the Department;

(B) are enrolled in the TRICARE program (as defined in section 1072 of title 10, United States Code);

(C) have employer-based or private insurance;

(D) are enrolled in the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(E) are eligible to receive health care furnished by—

(i) the Indian Health Service;

(ii) Tribal health programs; or

(iii) urban Indian organizations; or

(F) are uninsured.

(3) Recommendations for legislative and administrative actions to increase access to mental and behavioral health care for pregnant and postpartum veterans who screen positively for maternal mental or behavioral health conditions.

(4) Recommendations to address homelessness, food insecurity, poverty, and related issues among pregnant and postpartum veterans.

(5) Recommendations on how to effectively educate maternity care providers on best practices for providing maternity care services to veterans that addresses the unique maternal health care needs of veteran populations.

(6) Recommendations to reduce maternal mortality and severe maternal morbidity among pregnant and postpartum veterans and to address racial and ethnic disparities in maternal health outcomes for each of the groups described in subparagraphs (A) through (F) of paragraph (2).

(7) Recommendations to improve coordination of care between the Department and non-Department facilities for pregnant and postpartum veterans, including recommendations to improve—

(A) health record interoperability; and

(B) training for the directors of the Veterans Integrated Service Networks, directors of medical facilities of the Department, chiefs of staff of such facilities, maternity care coordinators, and staff of relevant non-Department facilities.

(8) An assessment of the authority of the Secretary of Veterans Affairs to access maternal health data collected by the Department of Health and Human Services and, if applicable, recommendations to increase such authority.

(9) To the extent applicable, an assessment of potential causes of or explanations for lower maternal mortality rates among veterans who have health care coverage through the Department of Veterans Affairs compared to maternal mortality rates in the general population of the United States.

(10) Any other information the Comptroller General determines appropriate with respect to the reduction of maternal mortality and severe maternal morbidity among pregnant and postpartum veterans and to address racial and ethnic disparities in maternal health outcomes for veterans.

(c) DEFINITIONS.—In this section, the terms ''Tribal health program'' and ''urban Indian organization'' have the meanings given those terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

The bill (S. 796), as amended, was ordered to be engrossed for a third reading, was read the third time, and passed.

Mr. LUJÁN. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The senior assistant legislative clerk proceeded to call the roll.

Mr. LUJÁN. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. LUJÁN. Madam President, I move to proceed to executive session to consider Calendar No. 261.

The PRESIDING OFFICER. The question is on agreeing to the motion.

The motion was agreed to.

The PRESIDING OFFICER. The clerk will report the nomination.

The legislative clerk read the nomination of Christine P. O'Hearn, of New Jersey, to be United States District Judge for the District of New Jersey.

CLOTURE MOTION

Mr. LUJÁN. Madam President, I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion.

The legislative clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, do hereby move to bring to a close debate on the nomination of Executive Calendar No. 261, Christine P. O'Hearn, of New Jersey, to be United States District Judge for the District of New Jersey.

Charles E. Schumer, Brian Schatz, Benjamin L. Cardin, Robert Menendez, Tammy Duckworth, Christopher A. Coons, Kirsten E. Gillibrand, Jacky Rosen, Patrick J. Leahy, Mazie K. Hirono, Margaret Wood Hassan, Jack Reed, Sheldon Whitehouse, Tammy Baldwin, Richard J. Durbin, Chris Van Hollen, Tina Smith, Ben Ray Luján.

ORDER OF PROCEDURE

Mr. LUJÁN. Madam President, I ask unanimous consent to withdraw the cloture motion on Calendar No. 364 and that the mandatory quorum call for the cloture motion filed today, October 7, be waived and that the cloture motion ripen at 11:30 a.m. on Tuesday, October 19.

The PRESIDING OFFICER. Without objection, it is so ordered.

LEGISLATIVE SESSION

MORNING BUSINESS

Mr. LUJÁN. Madam President, I ask unanimous consent that the Senate proceed to legislative session and be in a period of morning business, with Senators permitted to speak therein for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

TEXAS ABORTION BAN

Mr. DURBIN. Madam President, last night, a Federal judge in Texas did what the U.S. Supreme Court should have done. He issued an injunction blocking Texas' clearly unconstitutional bounty hunter abortion ban from being enforced while challenges to the law make their way through the courts. The ruling by U.S. District Judge Robert Pitman came in response to a challenge of the Texas ban brought by the Federal Department of Justice.

The Texas abortion law, known as S.B. 8, is the most restrictive abortion law in the Nation and the most serious challenge to Roe v. Wade in 50 years. It was deliberately crafted to outlaw most abortions while allowing State lawmakers to evade judicial review. It deputizes private citizens to enforce the ban by suing anyone who ''aids and abets'' a woman seeking an abortion. And it offers rewards of $10,000 or more to plaintiffs who bring suits.

In his ruling, Judge Pitman wrote that Texas politicians had ''contrived an unprecedented and transparent statutory scheme'' that has ''unlawfully prevented [women in Texas] from exercising control over their lives in ways that are protected by the Constitution.''

The Supreme Court order allowing the Texas law to take effect was a product of the Court's ''shadow docket'' of cases that are decided without full briefing or oral arguments—and without transparency or accountability.

The 5–4 order, from the Court's conservative majority, was criticized by some of the Court's own members, including Chief Justice John Roberts, who warned that Texas lawmakers had created a ''model for action,'' that other States could copy to undermine constitutionally protected rights.

The Chief Justice was right. Since the Court's ruling on S.B. 8, elected officials and political candidates in a number of States have vowed to introduce similar abortion bans.

With Judge Pitman's wise ruling last night, that rush to use citizen bounty hunters to avoid legal accountability while denying the constitutional rights of women and perhaps others is on hold—at least for now. But the threat to constitutional rights remains. Texas has already filed a notice of appeal in the conservative Fifth Circuit.

Abortion providers remain at risk of facing bounty hunter lawsuits if they perform abortions prohibited by the ban while the injunction is in place. Anti-choice organizations have vowed to be ''vigilant'' in suing individuals retroactively if the order is reversed.

I hope that justice—and the Constitution—will prevail in the coming days as this litigation continues. The fundamental rights of millions of Texans are at stake.

HISPANIC HERITAGE MONTH

Mr. CARDIN. Madam President, I rise today in recognition of Hispanic Heritage Month to celebrate our Hispanic and Latino communities and their immeasurable contributions to our Nation. Hispanic and Latinos have been with our country since its very founding and have helped make America exceptional. Hispanic and Latino Americans play vital roles in our communities. They are our teachers, our heathcare heroes, our entrepreneurs, our essential workers, our public servants and elected officials, all vital to the fabric of our Nation.

Hispanic Heritage Month started as a commemorative week that Congress established in 1968 and expanded to a full month in 1988 to recognize the critical role the Latino community has played in the civil rights movement. Celebrations start September 15, a significant date, as it is the independence date for Costa Rica, El Salvador, Guatemala, and Nicaragua, while Mexico celebrates its independence on September 16, and Chile celebrates its independence on September 18.

This month, we celebrate the nearly 61 million Latino Americans across the country and the more than 600,000 Hispanic or Latino residents in Maryland. Maryland is proudly one of the most diverse States in the Nation. We are home to people with origins in Central and South America, with sizeable populations of Salvadorans, Guatemalans, Puerto Ricans, and Mexicans.

America is a nation of immigrants; people from far and wide have settled in the United States, the land of opportunity. Since the Immigration Act of 1965, millions of individuals from Central and South America have immigrated to the United States for numerous reasons, including economic instability or violence in their native country.

We take this month to highlight the importance of the Hispanic and Latino communities, including the election in 1822 of Joseph Marion Hernandez, the first Hispanic in Congress, as Florida's Delegate. Today, according to the Congressional Research Service, there are 54 Hispanic or Latino Members—a record number—serving: 47 in the House, including two Delegates and the Resident Commissioner, and seven in the Senate.

Though the Hispanic and Latino communities have been essential to America's identity, from the scientific innovation to art, culture, music, food, and so much more, we must still recognize the disparities that these communities face. For the second year, we are celebrating Hispanic Heritage Month during the COVID–19 pandemic. The pandemic has affected people of color at disproportionate rates in terms of economic distress and case severity. The Hispanic or Latino unemployment rate soared to 18.9 percent in February of 2020. Hispanic or Latina women took even larger losses compared to their male counterparts. The unemployment disparity is due to the overrepresentation of Hispanic or Latino workers in the food preparation or serving industry, as well as building and grounds cleaning and maintenance. These sectors suffered some of the harshest economic effects of the pandemic. Even though the unemployment rate has decreased to 6.4 percent in Hispanic and Latino communities—6.2 percent in Maryland—they still have not experienced the same economic recoveries as their White counterparts.

For the immigrants who do not have a green card, their likelihood to have lost a job is even higher. Many say that at least one family member in their household has lost a job or wages. Families are suffering; they are worried about putting food on the table or even losing their homes. The financial toll of the last year and a half has exacerbated the prepandemic inequalities that the Hispanic or Latino communities were already facing.

Hispanic or Latino people are also more likely face the harshest health effects of the COVID–19 pandemic. According to the Centers for Disease Control and Prevention, Hispanic or Latino people are twice as likely to catch COVID, 2.8 times more likely to be hospitalized, and 2.3 times more likely to die compared to their White counterparts. In my own home State, Hispanic or Latino people are 14.3 percent of the case rates when they only make up 10.6 percent of our population. With the widening gaps of healthcare coverage, Hispanic or Latino families face large hospital bills for their bouts of COVID. Twenty percent of nonelderly Hispanic or Latino people are